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Estimation of Fairness in Health Financing Among Internally Displaced Persons and Local Population in Samegrelo Region of West Georgia

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LIST OF ABREVIATIONS

BBP	Basic Benefit Package
GEL	Georgian Lari
GoG	Government of Georgia
FFC	Fairness in Financial Contribution
HCP	Health Care Providers
HFC	Health Financing Contribution
IDA	International Development Association
II	Inequality Index
MoLHSA	Ministry of Labour, Health and Social Affairs
MoRA	Ministry of Refugees and Accomodation
MoE	Ministry of Economy
MoF	Ministry of Finance
PHC	Primary Health Care
PHD	Department of Public Health
PREGP	Poverty Reduction and Economic Growth Paper
SISUF	Social Insurance State United Fund
SMIC	State Medical Insurance Company
STD	Sexual Transmitted Diseases
STI	State Tax Inspectorate
TB	Tuberculosis
TORs	Terms of Reference
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

1. Background

This paper presents findings of the research project supported by International Policy Fellowship Program. The objectives of the research project were: To assess the fairness in health financing among Internally Displaced Population (IDP)and local population through computing Health Financing Contribution (HFC) Inequality Index (II) and Fairness in Financial Contribution (FFC) indices according to the WHO methodology and conduct comparison of two socio economic groups[1]; To examine poverty level and vulnerability of IDPs and identify factors negatively affecting their health status; To elaborate policy recommendations on the issues of health financing for the Government of Georgia (GOG), Ministry of Labor, Health and Social Affairs (MoLHSA) and other stakeholders.

Calculation of indices to estimate fairness of health financing of IDP and non-IDP households was based on estimates from household income and expenditure surveys and defined as the ratio of total household spending on health to its permanent non-subsistence income[2], or capacity to pay. Total household spending on health included payments towards the financing of health services through out-of pocket payments, premiums paid to private insurance or community health financing schemes, social insurance, and taxation. The definition of Fairness of Health Financing was constructed entirely from monetary estimates of contributions into the health care system. The methodology is focused on how health care was financed by households through out-of-pocket payments, tax contributions, social insurance, and prepayment schemes.

To allow for comparisons, the distribution of fairness of financing across IDP and non IDP households has been summarized using a Health Financing Contribution index[1]. The index was designed to weight heavily those households that have spent a very large share of their beyond-subsistence income on health. The index makes it possible to rank different socio economic groups such as IDP and non IDP based on the attained score.

[1] WHO Fair Financing Methodology, 2004. Kei Kawabata, Felicia Knaul, Ke Xu, Patrick Lydon.
[2] According to the WHO Methodology permanent non-subsistence income of a household is estimated as total income and tax payments, minus it's expenditure on food.

2. The Concept of Fairness of Health Financing

How the health systems are financed can have a profound effect on populations' access to healthcare and thus on the health status of each individual. Much of the public discourse in countries undertaking health sector reform is focused on the design of health financing system and achieving its fairness. According to World Health Organization (WHO) one of the challenges common to health systems in developing countries is to achieve fairness in the distribution of the financing burden, and protection of households from the risk of financial loss[3]. The fairness of health financing is a subset of the three main goals of health systems that are good health, responsiveness, and fair finance[4].

Fairness in health financing and protection against financial risk is based on the notion that every household should pay a fair share for health services. Fairness in financing embraces two critical aspects: risk pooling between the healthy and the sick and risk sharing across wealth and income levels. Risk pooling denotes the premise that the contributions for those that are healthy pay for the care of those that are sick, so that individuals who become sick are not struck by a double burden of sickness and financial costs of health care. Over the life span, each individual is likely to benefit from the financial security of risk pooling when she or he becomes sick. Risk sharing, while similar, refers to the premise that fairness does not mean equal contributions from all, regardless of income or wealth, but that contributions are greater from those who have more financial resources. In practical terms, embedding these notions of fairness financing is a step towards preventing the financial impoverishment of households when one of the members becomes ill.

According to the fairness in health financing study, conducted in 1999 with the support of the World Health Organization in 148 countries, Georgia scored among last twenty with the worst FFC index among post communist countries[5].

[3] Christopher JL Murray, Julio FrenkA WHO Framework for Health System Performance Assessment.
[4] Discussion Paper No.6, November 1999. Health System Performance Assessment, WHO, Geneva.
[5] World Health Report 2000, WHO, Geneva.

3. Health Financing System in Georgia

The health sector reform initiated by the government of Georgia in the mid 1990s was incited by the deep crisis in the health care system experienced after the dissolution of the Soviet Union, followed by major economic breakdown, civil unrest and armed conflict. The initial reforms envisioned transformation from a national health service to a social health insurance system, with substantial changes in the roles and responsibilities of the central and local governments. It was intended that the state would have a stewardship function through strong regulatory, financing, and licensing mechanisms while moving away from the actual provision of care. An IDA-financed project was approved in 1996 to support specific components of health financing reform. While clearly having made some progress in reforming the health system, most of these reforms have not reached the level of the consumer and have insufficient impact on the quality or accessibility of health care. Heath care financing still remains the major issue that is aggravated by excessive human and institutional capacity.

According to the Law on Health Care, article 37,[6] all citizens of the country are entitled to free medical services included in a Basic Benefit Package. However, due to insufficient financing of state health programs and financial barriers large part of the population, mostly poor and disadvantaged, are still deprived of even basic health care services which contradicts the State Health Care Strategy described in the Poverty Reduction and Economic Growth Paper (PREGP).

The main purpose of introduction of BBP in 1995 was to offer free and equitable access to quality health services for all citizens of the country. In 2003 the BBP consisted of 26 State health care programs and 5 municipal programs.

Georgian health care system is financed through public and private funds. Public funds mainly come from social insurance and central and municipal budgets while Private financing comprises of official direct payments done by the patients to health providers through so called “internal standards” as well as unofficial payments out of pocket.

[6] Constitution of Georgia, 1995.

A major problem related to Public health funds is that in reality the amount effectively transferred from Central budget to the recipients - Public Health Department and Social Insurance State United Fund to finance health programs significantly differed from the amount initially approved by the Parliament. In 2000 only 60% of the budgeted amount was actually received, in 2001 and 2003 88% and 67% respectively. In spite of the fact that actual financing of state health programs has been a chronic problem during past years, planned budget for health programs has been increasing from year to year. Due to this mismatch between the planned and actual financing of the system the SISUF was not able to cover the costs incurred by the providers for providing services under BBP, therefore providers charged informal fees the BBP beneficiaries to cover the negative balance. The poor couldn't afford to pay the informal fees and either got lower quality of care, were rejected of free care or preferred not to seek medical care at all.

Amount of money available for state funded health programs is a function of on the amount of collected social taxes during the year. In Georgia social taxes are collected by State Tax Inspectorate (STI) on a monthly basis according to the employers' declaration of social contributions. With the existing system the STI is facing significant problems that hinder appropriate tax collection. The STI is unable to determine whether the amount collected through social taxes corresponds to the salaries paid by employers. Because of the inexistence of personal ID numbers it is impossible to identify aggregate taxable monthly income of individuals.

Final recipients of the public funds for health care have been licensed, private and public health care providers contracted by SISUF and PHD. Health providers have been paid according to the monthly invoices submitted to SISUF and PHD. However, because of insufficient funding, provider reimbursement has been delayed for several months, if ever paid. At the same time, due to inappropriate invoice verification and processing systems there have been several cases of fraud, "ghost" payments and double payments to providers[7].

[7] Aufret P. Primary Health Care Financing in Georgia, 2003

According to law municipalities should allocate at least 10% of their budget for health care expenditures, however, because municipalities face the same problems as the center regarding tax collection, the former also are unable to allocate full amount of planned health budget to health services. Because of lack of central as well as municipal financing providers require from patient out-of-pocket payments, either in form of official fees or in form of "under the table payments" which remains the most popular payment method.

In rural areas according to the standards of MoLHSA one PHC facility should provide medical services to the population of up to 2500 people, however, due to the lack of financial resources, inadequate/obsolete equipment, delayed physician's salaries, absence of medical supplies and pharmaceuticals and due to the fact that patients are asked to pay out of pocket for free medical services the number of patients visiting PHC facilities is very limited and many people prefer self treatment or non-traditional methods of healing.

Private Resources

Private financing of health care services remains the most prevalent way of getting health services for the majority of population, both in urban and rural areas. According to the survey up to 85% of the respondents paid out of pocket for their health care. Most of these payments were unofficial and couldn't be registered. During 2003 up to 55% of out- of-pocket payments went to pharmaceuticals, 25% to secondary health care, 20% to primary health care services and 5% to other services[8]. The prevalence of out of pocket payments was the major reason for the increased number of households making catastrophic payments for health care, the main cause leading households into poverty.

Different surveys and sources also indicate that the main sources of health financing are out of pocket payments to health providers which made up 80-85% of total health expenditure in the country. Private health insurance in Georgia is still on early stages of development and approximately 1% of the population gets health services through private insurance. Private insurance is based on the principles of risk selection which creates

[8] "Population's health care expenditures and unrecorded medical service" EU 2003.

barriers for the participation of elderly and chronically ill people in these schemes. The taxation system is another barrier for the development of private insurance business in the country since insurance premiums paid by employers and employees are subject to taxation in Georgia.

Community based health financing schemes established in various regions of the country represent effective possibility for financing health care, especially primary health care and pharmaceuticals. Participants of such schemes are usually people who are self employed or are engaged in so called informal sector of the economy (farmers, small entrepreneurs etc.) Most of these people don't pay any state or local taxes and therefore don't contribute to the social security system. Community based health financing has become operational thanks to the financial support of various international donors and development organizations working in the country (EC, Care, Oxfam GB, Novib etc).

4. Current Situation of IDPs

One of the research objectives was to examine current situation of IDPs in terms of poverty level and vulnerability. The household income & expenditure survey (HH survey)[9] shows that a greater percentage of IDPs, primarily those living in collective centers, live in extreme poverty, have more health related problems and have greater rates of health services utilization. At the same time IDPs living in private accommodations are better off than IDPs living in collective centers and their living standards are about the same as that of the general population.

Income

According to different sources more than half of Georgian population live below the officially determined poverty line. According to Statistical Yearbook of Georgia the average monthly income per person decreased from 79 GEL in 1999 to 60 GEL in 2003. According to IPF supported household survey (HH survey), during 2003, IDPs received monthly State allowance of 24 GEL. For 36% of IDPs State allowances were the main source of income. 23% of IDPs named financial aid provided by relatives, friends etc. as

a main source of income. In addition to IDP benefits, elderly IDPs were eligible for state paid pensions. According to the survey an average household monthly income in 2003 for IDPs was 174 GEL comparing to 280 GEL for general population (reference this survey). According to the survey greater percentage of IDPs borrow money to visit health providers and get medical services most of which should be provided for free under BBP. Usually they borrow money from relatives and friends because access to credits offered by financial institutions for IDPs is limited. This is because of little or unstabile income and requirement of collateral and guarantees in form of liquid assets. Another reason why micro-finance institutions wouldn't lend money to IDPs is that most of the money is spent on so called Non-productive goods such as food, medicines etc. rather than on income earning activities that generate resources to repay the loan.[10]

Employment

Most of the surveyed IDPs are self-employed in small trade business while local population in agricultural sector which is due to the better access to land among local residents. IDPs living in capital of Tbilisi are much better off in terms of wage employment than IDPs living in regions and rural areas of Samegrelo and Imereti. The HH survey showed that up to 55% of economically active IDPs are unemployed. High unemployment rates in the country and high rates of self employed population who do not contribute to the social security system at all adversely affect fairness in health financing. For unemployed population and elderly the State provided social aid and pension (8 USD and 13 USD) is hardly enough to cover very essential expenditures on food and medicines not to mention electricity, gas, transportation etc. and is a main reason of high proportion of families making catastrophic payments for health care.

Accommodation

There are three types of housing where IDPs have been accommodated.

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[9] Household Income & Expenditure Survey was conducted in Zugdidi, West Georgia with the support of IPF by the researcher in August 2003

[10] Poverty and Vulnerability Among Internally Displaced Persons in Georgia: L. Darshem, N. Gurgenadze

- Collective centers (former hotels, hostels, schools, hospitals, etc) owned by state;
- Private housing owned by relatives/friends and rented or purchased apartments;
- Abandoned apartments or houses in rural areas.

According to the Ministry of Refugees and Accommodation, more than 40% of IDPs are accommodated in collective centers and 50% in private accommodation and the remainder in other types of accommodation. Collective centers often do not meet even minimum living standards which was IDPs' main concern so far. Local NGOs believe that many of the IDPs that originally purchased housing have sold it, and moved to collective centers, because they have exhausted their savings and their inability to earn a regular income. In collective centers each IDP occupies from 8 to 9 m^2 per person compared with 16-18m2 for the local rural population and $32m^2$ for the general population[11]. Due to the increasingly high cost of electricity most of IDPs can't pay their bills especially during winter time. In 2002, IDPs reported having on average 7 hours of electricity per day in winter months compared to that of 9-10 hours for general poulation. IDPs in collective centers in west Georgia primary use wood for cooking and heating during winter months. The result of bad living conditions is deteriorated epidemiological situation, higher rates of visits to health providers and increased OOP health expenditures.

Health Care of IDPs

According to Article 5 of the Georgian Law on IDPs State authorities shall provide IDPs with free medical aid. Cost of treatment at state-funded medical institutions shall be compensated by the state according to the established standards. The same law determines that handicapped, old, children and families lacking a breadwinner should be provided free medications. According to the HH survey most of IDPs were aware about State funded free medical programs and services described in detail before. However, the real situation is different. About 68,5% from interviewed 1893 households (HH) named

[11] Ministry of Refugees and Accommodation, 2002.

the financial difficulties as a major reason for not seeking medical treatment in case of need. These people preferred self treatment or non-traditional methods for treatment.

For those IDPs who afforded paying for health care the most popular place to seek treatment was district policlinic which serves both IDP and non IDP population. Specialized IDP policlinic located in the same Zugdidi city is less popular and twice less IDPs visit this facility. IDPs named village health post as a most affordable medical facility where medical treatment or consultation in most cases costs less than 5 GEL ($2.5). Only 4 out of 619 IDP HH who had medical problems during the year spent more than 500 GEL ($250) on doctor consultations and medical and diagnostic procedures.

As for drug related expenditures, 20% of IDPs spent from 50 to 500 GEL, the amount that in most cases exceeded an average monthly income of IDPs (124GEL). About 55% of IDPs spent from 11 to 50 GEL on drugs, which, given the miserable monthly incomes of IDPs, can be considered as catastrophic expenditure pushing many households in to poverty.

Transportation to health facilities was another financial barrier that limited access to health services for IDPs. 25% of IDPs, in addition to treatment and drug related expenditures, spent significant amounts of their income on transportation to health facilities.

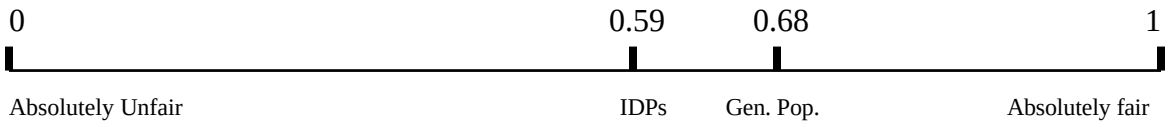
About 17% of interviewed households indicated that they were members of Community Health Financing Scheme (CHFS) established in Zugdidi district for IDP and non-IDP population with the support of various international organizations. Members of CHFS receive free medical treatment and essential drugs for monthly membership fee of 2GEL ($1) per household. Patient satisfaction with health services provided through CHFS was much higher than through State Social Iinsurance system. 63,5% of CHFS members expressed their satisfaction with CHFS and only 6% weren’t satisfied, the rest were partially satisfied. The surveyed HH were well informed about CHFS and prefered

paying community member fees to paying state health and social taxes to get PHC services and drugs. 86% of non-participants expressed willingness to participate in CHFS if such a scheme were established in their community.

Although the median health care expenditures were similar, IDPs had more visits to hospitals and pharmacies than the general population. Due to bad living conditions, lack of stable and adequate income, mental stress, poor health seeking behavior and life style prevalence of diseases was higher among IDPs than among local population. The information obtained from the HHs highlighted the prevalence of chronic diseases among IDPs.

5. Estimation of Fairness in Health Financing

HFC, FFC and II have been calculated according to the above described methodology elaborated at World Health Organization[12]. In 2003, FFC index for general population has been estimated as 0.68 and for IDPs as 0.59[13].



The FFC index was derived from the HFC of individual household and varied from 0,001 to 0,889. Georgia scored the lowest on FFC index compared to 19 other countries whose FFC index estimates were available for 2003.

[12] WHO Fair Financing Methodology, 2004. Kei Kawabata, Felicia Knaul, Ke Xu, Patrick Lydon.
[13] The detailed calculations of HFC, FFC and II are available in the database.

Table 1. Fairness in Health Financing and % of Households Making Catastrophic payments for Health[14]

N	Country	Fairness in Financing Contribution	% of Households With Catastrophic Payments
1	Slovakia	0.941	0.00
2	UK	0.921	0.33
3	Canada	0.913	0.48
4	Germany	0.913	0.54
5	Hungary	0.905	0.96
6	Czekh Republic	0.904	0.01
7	Slovenia	0.890	1.88
8	France	0.889	0.68
9	Thailand	0.888	0.99
10	Kyrgyzstan	0.875	1.32
11	Lithuania	0.875	1.68
12	Switzerlsnd	0.875	3.03
13	Estonia	0.872	2.47
14	USA	0.860	3.23
15	Latvia	0.828	4.05
16	Ukraine	0.788	6.82
17	Vietnam	0.762	11.46
18	Azerbaijan	0.748	11.27
19	**Georgia**	**0.680**	**11.72**
20	**Georgia IDPs**	**0.584**	**45.27**

The Inequality Index (II) has been estimated as 0.104 for IDPs and 0.08 for general population. The researcher wasn't able to obtain global data to conduct comparisons with other countries. However, it is likely that Georgia stands far bellow the average of other countries.

The health financing in Georgia is unfair not only compared to European countries but to CIS countries included in 2004 study as well. It is clear from the Table I, that percent of population making catastrophic payments is also very high, especially among IDPs. This is a typical situation for low and middle-income countries as well as some countries in transition and has a negative impact on household's health and socio-economic status,

[14] Assessing the Distribution of Household Financial Contributions to the Health System: Concepts and Empirical Application. Christopher J.L. Murray, Ke Xu, Jan Klavus, Kei Kawabata.

especially on those living in extreme poverty. It is clear from the table 1 that there is close correlation between the level of fairness in health financing contribution and number of households making catastrophic payments for health care. The lower is the FFC index for the country the higher is the percentage of households making catastrophic payments for health care. Unfortunately, the fairness of health financing has not changed during last four years, which leads to assumption that the issue has long been ignored on the health policy agenda of the country.

The issues of fairness in health financing and prevalence of catastrophic payments are closely linked to the poverty, health services utilization and failure of social security system to pool funds and health risks. The share of population facing catastrophic payments is a function of the poverty, insufficient pooling, and the utilization of services. The fairness in health financing has deteriorated in the country mostly due to the collapse of the risk pooling mechanisms.

The survey showed that the main reason of high percentage of households making catastrophic payments was prevalence of out-of-pocket payments for physician services and pharmaceuticals[15]. However, the HH survey showed that in some villages of Zugdidi district, community prepayment mechanisms such as Community Health Financing Schemes and Revolving Drug Funds played a significant role in reducing number of disadvantaged households through spreading the risks, prepayment mechanisms and pooling community funds. On the average 20% of local population benefited from such schemes and had access to pharmaceuticals, basic medical and diagnostic services for affordable membership fees. It can be concluded that the triad of poverty, availability of health services, and the absence of risk pooling mechanisms, are closely associated with the increase in catastrophic payments across the country.

As for Health Financing Contribution, it is very important to note that the distribution of HFC was difficult to capture because a lot of poor households, especially IDPs, chose not to purchase health care services or drugs due to their high prices and lack of purchasing power of households. In this sense, a fair distribution of HFC masked a situation where

[15] According do different sources percentage of HH making out-of pocket payments varied fro 75% to 85% in 2004.

poor households preferred self treatment or opted out of the system and didn't receive needed health services.

Another reason affecting fairness in health financing is the structure of existing health care system that tends to provide coverage mainly to the population with official employment status.. The self-employed population and agricultural workers and farmers, do not contribute or have no obligation to pay any social contributions to the system. This situation opposes the principle of social solidarity due to the fact that it is oriented towards some categories of socio economic groups and towards their incomes.

Once the problem has been identified, however, it is possible to improve the extent of fairness in health financing and reduce the number of families making catastrophic payments through putting the issues on the agenda of national health policy debate. Protection of people from catastrophic payments should become a desirable objective of health policy in the country. It is also worth to mention that, in Georgia, catastrophic health expenditures are not synonymous with high costs of health care as is the case in other countries. In this country even relatively small expenditures for common illnesses can be financially disastrous for poor households lacking insurance coverage. Policy makers, when designing health system, should address the issues and identify the characteristics of the system that make people more vulnerable to catastrophic payments. It is also important that policy makers identify those socio-economic groups that are more vulnerable to catastrophic health expenditures.

6. Recommendations

- The new Government should enhance the principle of solidarity in the design of health care finance system.

- It is necessary to set up mechanisms for monitoring and assessment of the performance of the health care finance system allowing disaggregation between IDP and non-IDP population, rural and urban, and between different income groups.

- The amount of public funds allocated by the State for health care programs and Basic Benefit Package should be increased and the efficiency of utilization of existing resources should be significantly improved. Without such changes, it will be impossible to implement new financial mechanisms oriented towards targeted groups and decrease the amount of households making catastrophic payments.

- It is important to define appropriate incentives and payment systems for health providers as well as regulate out-of-pocket expenditures and introduce co-payment systems where necessary.

- It is necessary to introduce effective management practices that would improve administration of state funds, institutional capacity of the payers and relationship with health providers and patients. Correct implementation of these mechanisms will move forward the health reform and will contribute to the development of a modern social security system in the country.

- Involvement of the regions in financing of local health care systems and providing subsidies to the poor population should be increased.

- Several Community Based Health Insurance Schemes have been established in the regions of Georgia with the support of I/Os and provide community members with basic medical care and pharmaceuticals for affordable prepayments. State should consider this as an alternative social security mechanism especially for the self-employed and farmers working in the rural areas of the country.

- It is necessary to conduct studies to assess fairness in health financing and distribution of household financial contributions to the health system on the Annual basis.

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